The IHS Dental Explorer

A publication of the IHS Division of Oral Health

April 2014

The IHS ECC Collaborative: Beginning the 5th and Final Year

In 2009, the Area Dental Officers voted to launch a national Early Childhood Caries (ECC) initiative. A small group of oral health professionals met at the Indian Health Service (IHS) Dental Updates meeting in Albuquerque, NM to form a steering committee, and outline a five year plan to significantly decrease ECC in Indian Country. The high prevalence of rampant dental decay in young American Indian / Alaska Native (AI/AN) children is documented in all IHS oral health surveys, ranging back to the first national surveillance effort of 1984, when the condition was labeled baby bottle tooth decay. Subsequent to the 1984 oral health survey, the IHS began extensive efforts to assist communities and parents in their efforts to curtail the inappropriate use of baby bottles. Over the years, a better understanding of the multifactorial nature of rampant decay led to a more complex approach to decreasing the prevalence of this infectious disease.

Subsequent to that first planning meeting, the following overall goal and milestone or process-based objectives were finalized, with the **overall goal being to decrease the prevalence of ECC in AI/AN children ages 0 – 5 by at least 25%.** Milestone or process-related objectives included:

- Increase the number of 0 – 5 year olds with at least one dental encounter per year by 25%.
- Increase the number of sealants placed annually on 0 – 5 year olds by 25%.
- Increase the number of 0 – 5 year olds receiving at least one topical fluoride treatment by at least 25%.
- Increase the number of interim therapeutic restorations (ITRs) in 0 – 5 year olds by 50%.

We have entered the final year of a 5-year effort. Whether or not all of our various interventions will make a significant difference in the prevalence of ECC in AI/AN preschool children remains to be seen. We will collect final descriptive data in the fall of 2014, in a fashion virtually identical to the way we collected data four years ago for our baseline assessment. Regardless of how our final assessment turns out, and whether or not we achieve our stated goal, a careful evaluation of the entire project should lead to a better understanding of what interventions aimed at ECC work in Indian Country, and which ones do not. This thoughtful analysis of the results of our 5-year effort will further knowledge concerning the treatment and prevention of ECC specific to the youngest members of the AI/AN population we serve.

An initiative of this magnitude requires the commitment and effort of hundreds of individuals. I am deeply and sincerely grateful to everyone who contributed, or will contribute in the coming months, to this important undertaking.

Timothy L. Lozon, DDS
Director, IHS Division of Oral Health

How have we done on the ECC Collaborative?

	FY 2006-2009 (4 years before Collaborative, cumulative totals)	**FY 2010-13** (1st 4 years of Collaborative, cumulative totals)	Goal (% increase)	So far (% increase)
0-2 year-olds accessing dental care	**56,124**	**59,121**	**25%**	**5%**
3-5 year-olds accessing dental care	**202,743**	**217,111**	**25%**	**7%**
Sealants provided to 0-5 year-olds	**59,637**	**94,881**	**25%**	**59%**
0-5 year-olds receiving fluoride	**124,020**	**185,007**	**25%**	**49%**
Interim therapeutic restorations in 0-5 year-olds	**14,612**	**34,204**	**50%**	**134%**

In the first four years of the IHS ECC Collaborative, IHS field programs have far surpassed the initial expectations as reflected in the objectives that were set for placement of sealants, provision of topical fluoride, and placement of interim treatment restorations. Access to care for 0 – 5 year olds has increased modestly. However, what we learned in our 2010 Basic Screening Survey of 0-5 year-old American Indian/Alaska Native children was that **TWO IS TOO LATE**: by the age of two, 44% of children have already experienced caries. Consequently, we (the national IHS ECC Collaborative Committee) feel that one of the keys to preventing ECC is early access to dental care, as soon as the first tooth erupts. So while a 5% increase in access for 0-2 year-olds is a nice increase, we must collectively focus on increasing access in this age group if we hope to prevent ECC.

In 2012, we embarked on a new project within the ECC Collaborative called the **Virtual Learning Community Program (VLCP).** This program consisted of one-on-one coaching by a national team and collaborative sharing through quarterly conference calls with all VLCP sites. We had a total of 39 field programs participate in that first year of the VLCP and 15 more programs joined in 2013. Many of the best practices we're sharing in this newsletter are the direct result of what we've learned from these 54 sites about what has worked and what hasn't worked in preventing early childhood caries.

How have we done on the ECC Collaborative?

Access to Care

- **ECC Collaborative Goal**

Increase access in 0-5 year-olds by 25% from 2005-09 to 2010-14

- **So far**

We've increased by 7% from 2010-2013 compared to 2006-09

- **What we need to do**

Increase 0-2 year-old access

Sealants

- **ECC Collaborative Goal**

Increase sealants in 0-5 year-olds by 25% from 2005-09 to 2010-14

- **So far**

We've increased by 59% from 2010-2013 compared to 2006-09

- **What we need to do**

Keep it up!

Patients Receiving Fluoride

- **ECC Collaborative Goal**

Increase 0-5 year-olds receiving fluoride by 25% from 2006-09 to 2010-14

- **So far**

We've increased by 49% from 2010-2013 compared to 2006-09

- **What we need to do**

Keep it up!

Interim Therapeutic Restorations (ITRs)

- **ECC Collaborative Goal**

Increase ITRs in 0-5 year-olds by 50% from 2006-09 to 2010-14

- **So far**

We've increased by 134% from 2010 -2013 compared to 2006-09

- **What we need to do**

Keep it up!

ECC Collaborative: system best practices

The following are best practices we learned from many of the successful programs that participated in the Virtual Learning Community Program.

Case Management: Assign one person to generate lists of children and provide exams, fluoride varnish, sealants, and ITRs. This person also becomes the "go to" person for families whose children need more dental treatment, often setting up appointments and arranging transportation. Be sure to provide follow-up after dental treatment is completed.

Collaboration: Work with the Women, Infants, and Children Program (WIC) by doing screenings at the WIC building or having WIC staff refer children to the dental department. Work with medical staff and community programs like daycare centers and Head Start to either refer children to the dental department or allow dental staff to screen young children in the medical department, daycare center, or Head Start center, respectively.

Local Champions: Identify someone who will "carry the torch" and excite everyone about ECC prevention. This might be a dental staff member, a public health nurse, a Tribal Council member, or someone else in the community that is committed to the prevention of ECC.

Training: Train dental staff to be comfortable treating young children. Teach staff how to use glass ionomer products for sealants and restorations on primary teeth.

Teamwork: Make the ECC Collaborative objectives a priority in your dental program. Consider providing **open access** for 0-2 year olds.

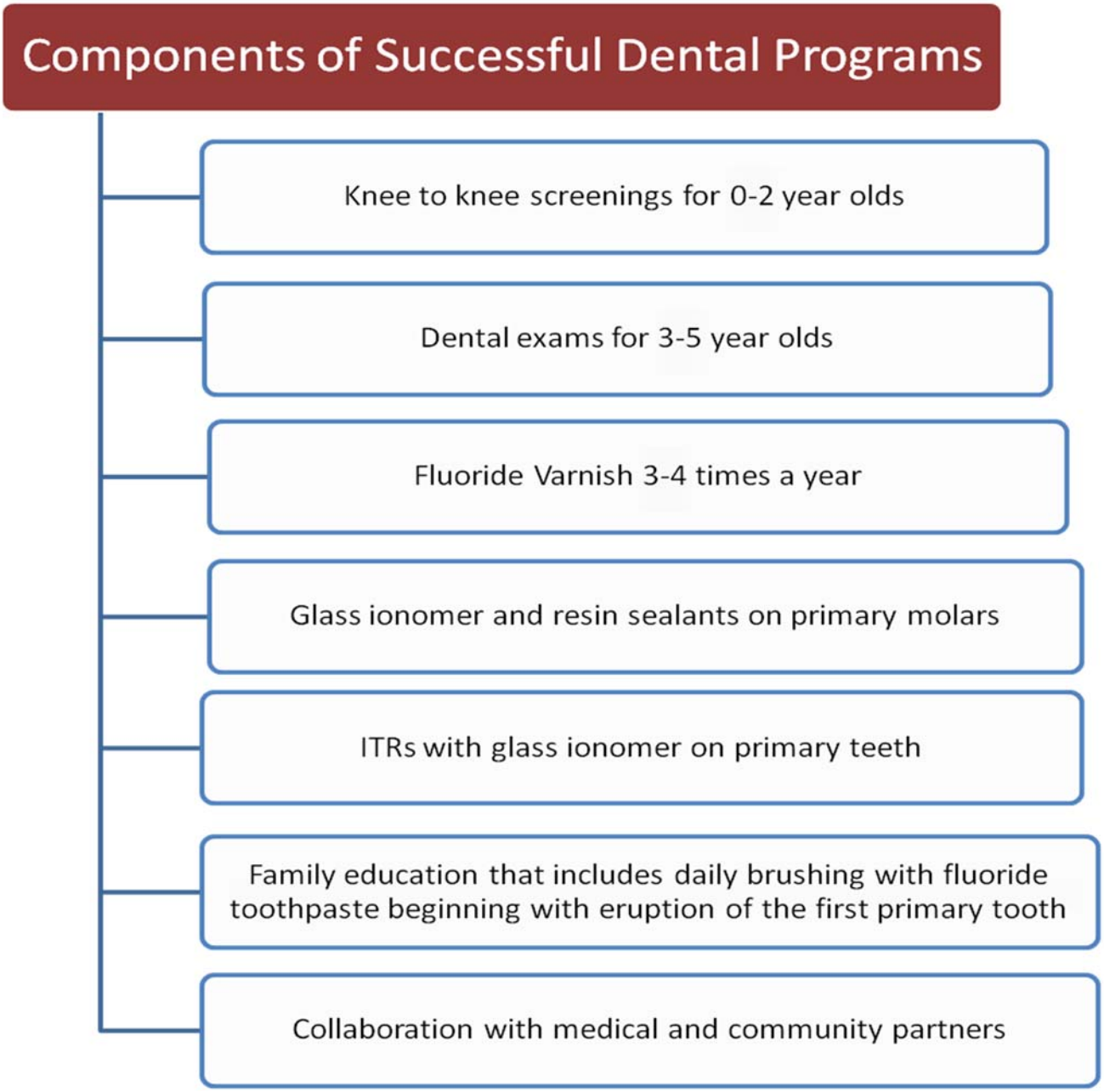
There are many ways to build effective ECC programs.

Which model will work in YOUR community?

ECC Collaborative: best practices for clinicians

The following are best practices we learned from many of the successful programs that participated in the Virtual Learning Community Program.

Programs that have so far shown the greatest improvements in the four ECC Collaborative process-based objectives of access, dental sealants, fluoride varnish, and ITRs have certain key characteristics in common:



Small Policy Changes → BIG Improvements!

As you puzzle what you might do to make a final push to increase access for 0-2 year olds, don't overlook policy changes. Simple policy changes have the potential to bring about significant increases in access to care and oral health for 0-5 year old children.

Last fall, the dental staff at the **Puyallup Dental Program** collaborated with key medical and administrative personnel to develop a new policy to increase dental access for babies. The Puyallup dental staff presented their concern that increasing access for 0-2 year olds was proving difficult. It was a medical staff member who suggested a policy change. Starting in December 2013, when the families of babies schedule a well-child appointment, they are also provided an appointment at the dental clinic. When they check in for well-child appointments, they receive their dental visit **first**. The dental staff provide a knee to knee exam, apply fluoride varnish, and provide family education. When the family is finished in dental, the dental staff call over to the medical clinic and let them know the baby and their family are on their way to medical. For more information on this program, contact Dr. Sean Kelly at sean@eptha.com.

The **Mississippi Band of Choctaw Indians Dental Program** approached the same problem (0-2 access) by working with their Women, Infants, and Children (WIC) Program. Over a decade ago, the Dental Department struck an agreement with WIC to require dental exams for all 0-5 year-olds prior to their biannual WIC recertification. This agreement did not require a tribal resolution or a formal memorandum of understanding, but rather just an interdepartmental agreement. For more information about this agreement, contact Dr. Brian Berg at brian.berg@choctaw.org.

Policy changes like this can be very effective ways to increase access to care for 0 – 5 year olds. We encourage you to work with your own medical staff and/or tribal council to consider policies in your own communities.

ECC Collaborative: best practices for clinicians

The new ECC videos contain brief messages targeted to the caregivers of babies and toddlers. These videos will be most effective if they are part of an overall health education plan. We have listed a few ways that they could be used but you may think of other ways to use these videos effectively.

⇒ If your health facility or dental program is already showing video loops in the waiting rooms, you can ask to add the ECC videos.

⇒ If you have a local TV station, you might meet with them to see if they would run the videos as public service announcements.

⇒ You can use one of the videos to begin an educational session with families. This might be a meeting with Early Head Start, pregnant moms, breastfeeding groups, etc.

⇒ The dental staff could use the video chairside when talking with the families of young children.

However you choose to use the videos, they will be most effective if they are followed up with a discussion about the messages in the video. You can ask caregivers what stood out to them, if they learned anything new, or if there is anything they might do differently because of the video. Finally, you can answer any questions caregivers may have and encourage them to bring their baby to the dental clinic.

The 4 new ECC videos can be downloaded from:

http://www.nappr.org/dental

Key elements to success: what works?

The following are best practices we learned from many of the successful programs that participated in the Virtual Learning Community Program. While we don't have data that prove exactly what it takes to succeed in ECC prevention, the list below are suggested keys to what our virtual learning programs think are the elements to success.

Organization

- An effective ECC Program requires a high level of organization and attention to details, especially in the development stage. The more organized you are initially, the smoother the program will run later on.

Commitment

- Your goal is to achieve a solid commitment from your own dental staff and also your medical and community partners. Find those champions in your own community who will commit themselves to the prevention of ECC.

Communication

- Good communication between the dental staff, medical staff, and community partners is essential. Furthermore, if you effectively market your ECC program to the families you serve, you can more effectively get them to join you as partners in the prevention of ECC.

Creativitiy

- Successful dental programs have been very creative. They have increased access through mailings, health fairs, and various other strategies. Instead of complaining that nothing works, the programs featured in this document have found new ways to address problems, often by thinking outside of the box.

Standout successes across the IHS!

Below is a list of top dental programs from around the country. Learn more about what they're doing to prevent ECC by contacting their dental chief or program manager.

Top increases in 0-5 year-old access to care % - 2006-09 to 2010-13

1. Catawba, Nashville Area—192%
2. Roger Saux, Portland Area—144%
3. Oklahoma City Indian Dental Clinic, Oklahoma City Area—88%
4. Four Corners Regional Health Center, Navajo Area—87%
5. Swinomish, Portland Area—79%

Explanation: This indicates that the number of 0-5 year-old children increased by 192% in the time period of 2010 to 2013 compared to the time period of 2006 to 2009 at Catawba (same explanation for other sites).

Top increases in 0-5 year-old access to care numbers—2006-09 to 2010-13

1. Hopi, Phoenix Area—1,077
2. W.W. Hastings Hospital, Oklahoma City Area—1,051
3. Rosebud, Aberdeen Area—1,023
4. Cherokee, Nashville Area—912
5. Sells, Tucson Area—797

Explanation: This indicates that the number of 0-5 year-old children increased by 1,077 in the time period of 2010 to 2013 compared to the time period of 2006 to 2009 at Hopi (same explanation for other sites). This is also the way you can read each of the following rankings below.

Top increases in 0-5 year-old sealants—2006-09 to 2010-13

1. Hopi, Phoenix Area—2,912
2. Anadarko, Oklahoma City Area—2,175
3. Woodrow Wilson Keeble, Aberdeen Area—2,168
4. Cass Lake, Bemidji Area—2,076
5. White Earth, Bemidji Area—1,433

Top increases in 0-5 year-olds receiving fluoride—2006-09 to 2010-13

1. Choctaw, Nashville Area—2,104
2. W.W. Hastings Hospital, Oklahoma City Area—1,953
3. Hopi, Phoenix Area—1,604
4. Cass Lake, Bemidji Area—1,399
5. Rosebud, Aberdeen Area—1,260

Top increases in 0-5 year-old interim therapeutic restorations—2006-09 to 2010-13

1. Ft. Peck, Billings Area—2,163
2. Pawnee, Oklahoma City Area—1,894
3. Blackfeet, Billings Area—1,443
4. Hopi, Phoenix Area—1,331
5. Cass Lake, Bemidji Area—901

Success Story #1

Program: Quentin N. Burdick Memorial Health Care Facility, Belcourt, ND (Aberdeen Area)

Accomplishment: Increased access in 0-5 year-olds by 44% from 2012 to 2013

How did they do it?

1. ***Empowered team members*** with authority and resources to achieve results. All staff completed the online caries stabilization course (www.ihs.gov/doh/ecc). All staff were encouraged to come up with ideas to try out.
2. Held frequent staff meetings to ***instill energy and enthusiasm*** into early childhood caries prevention efforts.
3. ***Blocked off*** Thursday mornings for 0-2 year-olds.
4. ***Provided open access*** in the dental clinic for any children age 5 and younger, meaning they could come into the clinic anytime for a screening and fluoride varnish application.
5. ***Worked with collaborative partners***—public health nurses, Head Start, daycare, and medical staff to get babies and toddlers into the dental program.

Point of Contact: Kay Witzel, kay.witzel@ihs.gov

Success Story #2

Program: Warm Springs Dental Program, Warm Springs, OR (Portland Area)

Accomplishment: Increased access in 0-2 year-olds by 232% from 2012 to 2013.

How did they do it?

1. Used lessons learned from the Improving Patient Care Initiative (IPC) to ***provide immediate access*** for well baby clinic patients. IPC focuses on reducing the "next available appointment," so dental learned what the medical department was doing to reduce wait times and decided to embrace open dental access for those babies and toddlers being seen in medical.
2. ***Worked with the Women, Infants, and Children Program (WIC)*** to provide education to WIC staff and to parents, concentrating on early access to care for babies and toddlers.

Point of Contact: Juanita Simpson – juanita.simpson@ihs.gov

Success Story #3

Program: Anadarko Indian Health Center, Anadarko, Oklahoma (Oklahoma City Area)

Accomplishment: Increased access in 0-5 year-olds by 70% from 2006-09 to 2010-13.

How did they do it?

1. ***Provided dental services in daycare centers***—fluoride, screenings, etc.
2. Instead of waiting for parents to bring children into the clinic, ***they took portable equipment*** not only to the daycare but also to the Head Start centers.

Point of Contact: Dr. Gloria King – gloria.king3@ihs.gov

Success Story #4

Program: Oklahoma City Indian Dental Clinic
(Oklahoma City Area)

Accomplishment: Increased access in 0-5 year-olds by 88% from 2006-09 to 2010-13.

How did they do it?

1. They first got ***buy-in*** from all of the dental staff and medical pediatric department staff. They got this support by educating staff and relaying the importance of ECC prevention.
2. Provided ***open access*** for 0-5 year-olds—open exam scheduling, accepting all 0-5 year-old walk-ins.
3. ***Promoted early childhood caries prevention*** to parents and the community through public service announcements, newsletters, and word of mouth.
4. ***Collaborated*** with the medical department to ensure referrals of babies and toddlers from medical to dental.

Point of Contact: Flauryse Baguidy – flauryse.baguidy@ihs.gov

The IHS ECC Collaborative Steering Committee

- Dr. Tim Ricks, IHS National Dental Public Health Consultant, *Co-Chair* (Albuquerque, Nashville Areas)
- Dr. Bonnie Bruerd, Northwest Tribal Dental Support Center Consultant, *Co-Chair* (Portland Area)
- Dr. Tim Lozon, Director, IHS Division of Oral Health, *Ex-Officio* (IHS Headquarters)
- Dr. Mary Beth Kinney, Director, Dental Continuing Education Program (IHS Headquarters)
- Dr. Jim Schaeffer, Deputy Director, IHS Division of Oral Health (IHS Headquarters)
- Dr. Patrick Blahut, IHS Oral Health Promotion/Disease Prevention Coordinator (IHS Headquarters)
- Dr. Craig Bruce, IHS National Pediatric Dental Consultant (Bemidji Area)
- Dr. Gary Pannabecker, Dental Chief, Blackfeet (Billings Area)
- Dr. Brandy Larson, Dental Chief, Cass Lake (Bemiji Area)
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- Travis Fisher, RDH, Director, Bemidji Area Dental Support Center (Billings Area)
- Melissa Reese, RDH, Director, Oklahoma City Area Dental Support Center (Oklahoma City Area)
- Lalani Ratnayake, Director, California Area Dental Support Center (California Area)
- Dr. Mary Beth Johnson, Pediatric Dentist, Hopi (Phoenix Area)
- Dr. Mark Meyers, Dental Chief, Chinle (Navajo Area)
- Lori Goodman, RDH, Rapid City (Aberdeen Area)

IHS ECC
EARLY CHILDHOOD CARIES COLLABORATIVE
Healthy Teeth Healthy Families

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